doi: 10.1111/1753-6405.12982

Trade and investment agreements as structural drivers for NCDs: the new public health frontier

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Noncommunicable diseases (NCDs) including cancer, heart disease, stroke and diabetes are responsible for more than seventy per cent of deaths worldwide and have been labelled an "invisible health epidemic" by the World Health Organization.[1] In Australia and New Zealand, NCDs are responsible for more than 89 per cent of deaths, and are cause for a large proportion of the health gap for low socioeconomic, Aboriginal and Torres Strait Islander, and Maori and Pacific populations.[2-7] Preventable risk factors for NCDs include smoking, harmful use of alcohol, poor nutrition and physical inactivity. In the recent decade, governments have committed to several high-level international declarations and action plans to reduce exposure to these risk factors.[8-11] At the same time, however, governments have expanded trade and investment agreements, which can facilitate greater access to cheaper health-harmful commodities and introduce new constraints on public health regulation.[12-14] In this commentary, we outline the ways in which trade and investment agreements can affect NCD risk factors, canvass the current trade landscape for Australia and New Zealand, and argue for multisectoral efforts to create healthy trade policy.

Trade agreements are structural drivers of NCDs

Increased consumption of health-harmful commodities (i.e. tobacco, ultra-processed foods and alcohol) is facilitated through governments' trade commitments to open up markets to foreign goods, services and investment, no matter their health implications. These include provisions that reduce tariffs (i.e. border taxes) on imports, harmonise rules, standards and procedures, and remove restrictions on foreign direct investment. These measures have generally increased both the volume of health-harmful commodity imports, as well as the local production, manufacturing and distribution of these products through increased foreign direct investment, alongside intensive marketing and advertising campaigns.[15,16] A recent systematic review found implementing trade policies and agreements correlated with "increases in imports and consumption of edible oils, meats, processed foods, and sugar-sweetened beverages".[12] For example, sales of sugar-sweetened beverages owned by foreign companies significantly increased following Vietnam's accession to the World Trade Organization (WTO) in 2007.[16]

Greater rights afforded to corporations through measures in trade agreements such as investor-state dispute settlement can interfere with efforts to regulate the sale of these health-harmful commodities. A well-known example is the decision by tobacco giant Philip Morris International to initiate ISDS arbitration with the government of Australia through a Hong Kong-Australia Bilateral Investment Treaty over its tobacco plain packaging legislation. The case highlighted the potential impacts on public health regulation and led to regulatory chill as several countries delayed implementing tobacco legislation while this and other WTO cases over tobacco disputes were ongoing.[17] While Australia won the case, it was still 12 million dollars out of pocket in legal costs,[18] demonstrating the financial costs that could deter low- and middle-income countries from introducing public health measures if they fear arbitration from multinational corporations.

Domestic health policy is also shaped more discreetly by the global trade regime through committees at the WTO, which oversee regulation affecting food, alcohol and tobacco labelling and safety standards. Within these committees WTO member states can raise specific concerns regarding measures that may affect their trade. For example, public health measures in Thailand, Chile, Indonesia, Peru and Ecuador to introduce mandatory front-of-pack interpretive nutrition labelling to tackle rising NCD rates have been raised as a trade concern within one such committee.[19] It has been suggested that countries considering implementing such measures will need to provide greater justification for these and scientific evidence for their effectiveness, and face pressures to implement less trade-restrictive measures such as education campaigns. Similar practices have been documented around alcohol labelling.[20]

Furthermore, trade agreements can affect access to NCD treatment. Expansive intellectual property rights in trade agreements, which include extending pharmaceutical monopolies, can keep medicine prices higher for longer.[21] New biologic medicines to treat cancer and other NCDs are increasingly expensive – in 2015-16 alone Australia spent more than two billion dollars on biologics.[22] More than 367 million would have been saved if cheaper biosimilars (i.e. similar follow-on products) were available.

Contemporary trade pressures for Australia and New Zealand

Australia and New Zealand face a raft of trade concerns amidst the ongoing trade war between the United States and China.[23] Both Australia and New Zealand have responded by doubling down on their commitments to the rules-based trading system and have entered trade negotiations for bilateral and mega regional trade agreements, such as the Comprehensive and Progressive Agreement on Trans Pacific Partnership (CPTPP) signed in 2018.[24]

Australia and New Zealand are currently negotiating the mega Regional Comprehensive Economic Partnership agreement (RCEP) with the ten ASEAN member states, India, China, Japan and the Republic of Korea. Like the CPTPP, RCEP is a new generation of trade agreements that includes negotiations beyond rules on goods, to include rules on services, intellectual property, regulatory harmonisation, investment, and ecommerce amongst

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other issues.[21] After more than seven years of negotiations, pressure is mounting on countries to sign the agreement within the next 12 months, with India suspending its participation due to concerns around access to medicines and agricultural tariffs.[25] Public health advocates have raised several concerns regarding the lack of transparency around the negotiations. Furthermore, analyses of leaked text have revealed pressures in the negotiations regarding patents on seeds, intellectual property enforcement and investor rights.[21] There have been no commitments by Australia or New Zealand to conduct an independent health impact assessment of the negotiations, nor to make the text available to public health experts or parliamentarians before it is signed.

Australia has also started negotiations with the European Union for an EU-AUS trade agreement. Unlike Australia, the EU has released its proposed texts online, revealing pressures to extend pharmaceutical monopolies.[26] While Australia has so far resisted pressures to extend monopolies in other trade agreements, there are legitimate concerns that the EU might offer market access deals in exchange for increased monopoly protection which, if Australia accepted, could affect access to NCD treatments.[27] These health concerns are also equity concerns as there is sufficient evidence that increases in the cost of medicines can lead to greater co-payments,[28] which disproportionately affects low-income groups, pensioners and Aboriginal and Torres Strait Islander Australians.[29] There is also evidence that greater co-payments can lead to lower rates of prescription medicine use.[30]

Promoting greater multisectoral coherence for healthy trade policy

Until governments consider the broader health and societal impacts of their trade and investment policies, NCD risk factors will likely continue to rise, thwarting efforts to reduce preventable deaths and morbidity.

One way to promote coherence is to institutionalise formal engagement between Departments of Health and Trade, such as Thailand has done through capacity building of health officials and interdepartmental committees.[31] The Australian Government is currently developing a 10-year National Preventative Health Strategy to improve health through 'early intervention, better information, and targeting modifiable risk factors and the broader causes of poor health'.[32] The plan, which will be discussed in draft form later this year, provides a window of opportunity for securing greater commitments to multisectoral policy engagement, including commitments for developing 'healthy trade policy' that aligns with NCD and broader health commitments. Australia at the very least could commit to independent health impact assessments of trade agreements before they are signed,[29] and could follow the EU in releasing their proposed trade texts to public and expert scrutiny. However, without meaningful engagement and high-level commitments by Minsters, health will continue to remain largely on the periphery of trade negotiations.

Public health practitioners and academics can play an important role in drawing attention to the NCD crisis and to the need for elevating health on trade policy agendas. In September 2019, the first Australian national capacity-building roundtable on trade and NCDs was held in Canberra for national health, medical, obesity, nutrition and other professionals.[33] The roundtable generated a suite of future activities for the public health community, including the need to demystify trade for public health practitioners and provide trade literacy for greater health engagement in trade policymaking. It is envisioned that these activities could help to create a broader community of health organisations, professionals and academics within both Australia and New Zealand and the Asia and Pacific region that can promote multisectoral action for NCDs.

Conclusion

Trade and investment agreements serve as structural drivers of NCD risk factors and can limit scope for public health regulation. Australia and New Zealand are negotiating multiple trade agreements behind closed doors, without independent health impact assessments or public participation. Healthy trade policy that pays attention to the potential health impacts, including NCD impacts of trade deals requires greater public health engagement. Trade literacy and other capacity building activities are needed to build public health practitioners' knowledge and participation in this important policy arena.

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